South Dakota Board of Nursing
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.state.sd.us/doh/nursing

Certified Registered Nurse Anesthetist & Clinical Nurse Specialist
General Instructions for Licensure Application

Please follow instructions carefully to avoid delays in processing your application. If any of the information on your application is incorrect, incomplete or illegible, processing of the application may be delayed. You can expect that it will take 4 – 6 weeks before all forms are received by the Board office, upon receipt of all forms your application will be considered for approval. You will be notified in writing if additional information is required or that your application has been approved.

❑ Application and Fees

1. Complete general application Form 1 and return to South Dakota Board of Nursing office.
2. The fee for licensure is $100 and must accompany the application. Fee payment should be in the form of a money order or a cashier's check payable to the South Dakota Board of Nursing. All fees are non-refundable. If a Temporary Permit is also desired, see Temporary Permit instructions below.

❑ Registered Nurse License

1. You must have a current, valid, unencumbered South Dakota RN license or temporary permit.
   - If not, complete RN Application for Licensure by Endorsement available at www.state.sd.us/doh/nursing.
2. *Or* – provide a copy of your current, valid, unencumbered compact RN license from your primary state of residence (where you hold a driver's license, pay taxes, and/or vote).
   - South Dakota is a member of the Nurse Licensure Compact, for more information on the Nurse Licensure Compact see www.ncsbn.org.

❑ Criminal Background Check — Required for CRNA and CNS who do not hold a South Dakota RN license and are not completing an application for a South Dakota RN license.

1. Pursuant to SDCL 36-9-97, ARSD 20:48:03:01, and ARSD 20:48:05:01, each applicant for initial licensure is required to submit a full set of fingerprints with completed application to obtain a state and federal criminal background check.
2. If you download an application off of the website (www.state.sd.us/doh/nursing) and submit the completed application to the South Dakota Board of Nursing, fingerprint cards will be mailed to you.
3. The fingerprint cards you receive from the SDBON **must** be the cards you use for fingerprints, since specific agency data are pre-printed on them.
4. Contact your local law enforcement agency for fingerprinting.
5. Send to the SD Board of Nursing office your completed fingerprint cards and a ***separate check*** or money order for $44 payable to: South Dakota Division of Criminal Investigation (DCI).
6. Your application will not be processed and/or temporary license will **not** be issued until your completed application **and** fingerprint cards are received.
7. You will **not** receive a permanent license until the fingerprint results from the Federal Bureau of Investigation (FBI) are received, approximately 1-2 weeks.
8. *Cards will be rejected if bent, folded, tampered with, stained, smeared or stapled. If rejected you will be notified to resubmit your cards.*

Continues

❑ Request for Transcript Form

1. Complete Transcript Request Form 2 and send to the Office of the Registrar for each applicable college, university, or program which awarded you a graduate nursing degree or post graduate certificate which prepared you for your advanced nursing specialty role.
2. The transcript(s) must evidence the degree conferred and the date.
3. The official transcript(s) must be sent directly to the Board office from the college, university, or program. Copies of transcripts are not accepted.
4. Contact the Registrar's Office/Organization to determine the appropriate fee to enclose for transcript/document service.

❑ Education Verification

1. You complete applicant section of Education Verification Form 3; send a copy to each applicable college, university, or program from which you were awarded a graduate or post graduate certificate nursing degree.
2. The Dean/Director or designated official of the program completes the remaining questions verifying education and accreditation status of the nursing program at the time of your attendance.
3. The Dean/Director or designated official of the program must return the completed form to the Board office.

❑ Certification Verification

Primary source verification of *successfully passing a standardized qualifying certification examination* specific to your area of practice or evidence of *current certification* from a Board-approved certification organization is required for licensure and renewal in South Dakota. Board-approved certification organizations include: Council on Certification of Nurse Anesthetists; American Association of Critical Care Nurses (CCNS exam), American Nurses Credentialing Center, National Certification Corporation for OB, GYN & Neonatal Nursing Specialties. Contact the Board office regarding whether other certification organizations are accepted for licensure.

1. Applicant completes top section of Certification Verification Form 4; forward to your certifying organization.
2. Contact certifying organization to determine appropriate fee to enclose.
3. The certifying organization will return completed form directly (primary source) to SD Board of Nursing.
4. CNS applicants, please note, if certified through NCC or ANCC, they require submission of requests for primary source verification on their websites.
5. CRNA applicant **by Endorsement** only: primary source verification of re-certification status will be obtained by the Board of Nursing via CCNA's online verification website. Complete Form 4 and return to the BON office with application. You do not need to send Form 4 to CCNA/AANA.

❑ Temporary Permit

To practice as a CRNA or CNS in South Dakota, you must possess a temporary permit or license issued by the Board of Nursing authorizing your practice. A temporary permit is required before you can begin orientation at your place of employment. A temporary permit is valid only for the period of time it has been issued and may not be renewed. Practice beyond the expiration date is a violation of law and may result in disciplinary action. The holder of a temporary permit to practice will use the designation of **CRNA app.** or **CNS app.** after name.

1. A **temporary permit by examination** is issued to an applicant waiting for results of the first exam they are eligible to take after completion of an approved education program. The temporary permit will be issued when the following is completed and received in the Board office:
   a. General Application – Form 1 with $100 fee.
   b. Temporary Permit Application – Form 5 with $25 fee.
   c. Verification of RN licensure: if you hold a "compact" RN license, other than SD, provide copy of license.
   d. Verification of education: Letter from nursing education program Dean/Director verifying completion of all program requirements *and* eligibility to sit for a national certification exam specific to specialty. – OR – Transcript verifying degree was conferred.
   e. Verification of examination eligibility: Documentation from certification organization that you are a candidate for the exam. – OR – Documentation from certification organization that you are awaiting results of the first exam for which you are eligible after graduation. – OR – Documentation from Dean/Director of nursing education program verifying eligibility to sit for a national certification exam specific to specialty.
   f. Fingerprint cards (*see Criminal Background Check above*)

Continues

2. A **temporary permit by endorsement** is issued to an applicant who holds licensure as a CRNA or CNS in another state and is awaiting licensure in South Dakota. The permit becomes invalid *90 days* from issuance date. The temporary permit will be issued when the following is completed and received in the Board office:
   a. General Application – Form 1 with $100 fee.
   b. Temporary Permit Application – Form 5 with $25 fee.
   c. Verification of RN licensure: if you hold a "compact" RN license, other than SD, provide copy of license.
   d. Verification of certification: Provide a copy of your current certification card from the certification organization – OR – Primary source verification of current certification on file with the Board sent by certification organization (See Form 4 below).
   e. Verification of current licensure: Provide copy of current CRNA or CNS license from another state or territory.
   f. Fingerprint cards (*see Criminal Background Check above*)

South Dakota Board of Nursing
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.state.sd.us/doh/nursing

CERTIFIED REGISTERED NURSE ANESTHETIST & CLINICAL NURSE SPECIALIST
GENERAL APPLICATION – FORM 1

Please Print

1. Name: First _____ Middle _____ Last _____

1. Other names previously used: _____

2. Address: _____
   Street/PO Box City State Zip
3. Telephone: Home: (___) _____ Other: (___) _____ Email: _____

4. Date of Birth: _____ Place of Birth: _____ Social Security #: _____

5. US Citizen: ❑Yes ❑No Gender: ❑Male ❑Female

6. Check title for which you seek licensure:
   - ❑ *Certified Registered Nurse Anesthetist* (CRNA)
   - ❑ *Clinical Nurse Specialist* (CNS)
     - ❑ Adult Health Nursing
     - ❑ Community Health Nursing
     - ❑ Critical Care Nursing
     - ❑ Psych-Mental Heath Nursing
     - ❑ Gerontologic Nursing
     - ❑ Pediatric Nursing
     - ❑ Diabetes
     - ❑ Other: _____

7. Have you been licensed as a CRNA or CNS in another state? ❑Yes (complete Question 8) ❑No (skip Question 8)

8. Advanced practice licensure history:

STATE	LICENSED AS	LICENSE #	DATE ISSUED	EXPIRATION DATE

9. Information regarding your professional nursing education that prepared you for nursing specialty:

INSTITUTION NAME	LOCATION (CITY, STATE)	COMPLETION DATE	PROGRAM TYPE
			❑Certificate ❑Master's ❑Post-Master's
			❑Certificate ❑Master's ❑Post-Master's
			❑Certificate ❑Master's ❑Post-Master's

10. Do you hold current certification from a national certifying organization?
    ❑Yes (complete Question 11) ❑No ❑Awaiting results of certification exam from: _____
    Specialty: _____

11. Information regarding your certification from a national certifying organization:

CERTIFICATION ORGANIZATION	SPECIALTY	CERTIFICATION #	DATE ISSUED	EXPIRATION DATE

Continues

12. Declaration of primary state of residence:

I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is:

_____. This is my "home state" under the Nurse Licensure Compact and is my "declared fixed permanent and principal home for legal purposes."

– OR –

❑ I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer:_____

RN License # in primary state of residence if other than South Dakota:_____

_____ _____

Applicant Signature Date

13. If you hold a "compact" RN license, other than SD, provide copy of license.

14. Disciplinary Information:

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? **If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.**	❑YES	❑NO
2.	Is there any pending criminal prosecution against you which would constitute a felony?	❑YES	❑NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	❑YES	❑NO
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	❑YES	❑NO
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	❑YES	❑NO
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	❑YES	❑NO
7.	Within the last two years, have you been treated for abuse or misuse of any alcohol or chemical substance?	❑YES	❑NO
8.	Within the last two years, have you experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	❑YES	❑NO
9.	Do you currently owe child support arrearages in the sum of $1,000 or more?	❑YES	❑NO
For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.			

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

_____ _____

Applicant Signature Date

South Dakota Board of Nursing
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.state.sd.us/doh/nursing

Transcript Request – Form 2

Applicant, please complete this form for each applicable college, university, or program that awarded you a graduate nursing degree or post graduate certificate which prepared you for your advanced nursing specialty role. Forward this form to the Office of the Registrar.

Please Print

1. Name: First_____ Middle_____ Last _____
2. Other names previously used:_____
3. Address:_____
   Street/PO Box City State Zip
4. Date of Graduation:_____ Social Security #:_____

I am requesting an official transcript (must bear raised or color coded school seal and evidence of the degree conferred and date conferred) of my nursing education be attached to this request and forwarded to the South Dakota Board of Nursing for licensure purposes.

_____ _____
Applicant Signature Date

Registrar:
Please return this form with the official transcript and
send to the South Dakota Board of Nursing at the address above.

South Dakota Board of Nursing
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.state.sd.us/doh/nursing

CERTIFIED REGISTERED NURSE ANESTHETIST & CLINICAL NURSE SPECIALIST
EDUCATION VERIFICATION – FORM 3

Applicant, complete items 1 – 6 on this form then forward to the Dean/Director for each nursing college, university, or program which prepared you for your nursing specialty role.

Please Print

1. Graduate Name: First_____ Middle_____ Last_____
2. Other names previously used:_____
3. Address:_____
   Street/PO Box City State Zip
4. Telephone: Home: (___)_____ Other: (___)_____ Email: _____
5. Date of Birth:_____ SS#: _____ I am submitting application for licensure as a: ❑CRNA ❑CNS
6. Consent to *Release Information* to the South Dakota Board of Nursing:
   - I have applied to the South Dakota Board of Nursing for a license to practice. After I have completed all program requirements, please complete this form and forward directly to the South Dakota Board of Nursing office for licensure purposes.

_____ _____
Applicant Signature Date

Program Director: After completed forward to the South Dakota Board of Nursing at the address above.

7. University/Institution Name_____ Location (City, State)_____
8. Program Graduation/Completion Date: _____ at the time the Applicant graduated, the graduate nursing program was accredited by:
   - ❑ Council on Accreditation of Nurse Anesthesia Educational Programs
   - ❑ Commission on Collegiate Nursing Education
   - ❑ NLN/National League for Nursing Accrediting Commission ❑ Other:_____
9. Type of Program (check one): ❑Certificate ❑Master's Degree ❑Post-Master's Certificate
10. Advanced role & specialty Applicant was educated in: ❑CRNA or ❑CNS *(complete questions below)*
    - Did the education program specifically prepare Applicant to function in the ***CNS*** role? ❑YES ❑NO
    - How was instruction completed? ❑Specific course work in ***CNS*** role development
      ❑***CNS*** role development integrated throughout the curriculum
      ❑Other:_____
    - Did the ***CNS*** education program have a clinical practicum that provided for the integration of the areas of education, research, consultation, and leadership into the clinical role? ❑YES ❑NO
      - If NO, did the education program have a clinical component in the curriculum? ❑YES ❑NO

_____ _____
Dean/Director Signature *or* Other Designated Official/Title Date

Place School Seal Here

If School Seal is no longer available, use either Agency/Institutional Seal, or so indicate.

South Dakota Board of Nursing
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.state.sd.us/doh/nursing

CERTIFICATION VERIFICATION – FORM 4

Applicant, complete items 1 – 8 on this form then forward to certification organization.

Please Print

1. Name: First_____ Middle_____ Last _____

2. Other names previously used:_____

3. Address:_____
   Street/PO Box City State Zip

4. Name of Certification Organization_____

5. Certification #_____ Expiration Date: _____

6. Certification status (check one): ❑ Initial certification verification ❑ Recertification verification

7. Certification type (check one): ❑ CRNA ❑ CNS ❑ CNM ❑ CNP

8. Consent to *Release Information* to the South Dakota Board of Nursing:

   I authorize the above named certification organization to disclose information regarding the identification, evaluation, and certification of the above named applicant that is maintained by the above named certification organization to the South Dakota Board of Nursing. I authorize the South Dakota Board of Nursing to utilize this information as needed for validation, investigation, litigation, discipline, or agreements concerning my nursing license. This authorization to release requested information shall expire at my written request. A copy of this request shall be as effective as the original.

_____ _____
Applicant Signature Date

Certification Organization: complete below then forward to South Dakota Board of Nursing at address above.

NAME OF CERTIFICATION ORGANIZATION_____

Certification #	**Date of Current Certification Maintenance Cycle/Recertified through:**
Certification type: ❑ CNM ❑ CNS – specialty area_____ ❑ CRNA ❑ CNP – specialty area_____	
Is certification current? ❑YES ❑NO (Please explain on a separate paper)	Has certification lapsed? ❑YES (Please explain on a separate paper) ❑NO
Has certification been revoked? ❑YES (Please explain on a separate paper) ❑NO	Is certification provisional/conditional in any manner? ❑YES (Please explain on a separate paper) ❑NO

_____/_____ _____
Name/Signature of person completing form Title Date

South Dakota Board of Nursing
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.state.sd.us/doh/nursing

Certified Registered Nurse Anesthetist & Clinical Nurse Specialist
Temporary Permit Application – Form 5

Please Print

1. Name: First_____ Middle_____ Last _____

2. Check title for which you seek temporary permit:
   - ❑ CRNA – app.: *Certified Registered Nurse Anesthetist*
   - ❑ CNS – app.: *Clinical Nurse Specialist*

3. Check type of temporary permit you are requesting:

❑ I am requesting a **temporary permit by examination**:

Name of Certification Organization	Exam Specialty Area	Date Exam Written – Or– Date Expected to Write Exam	Date Results Received or Date Results Expected

❑ I am requesting a **temporary permit by endorsement**. I currently hold a CRNA or CNS license in another state or territory.

4. List information about each facility where you will be practicing on this temporary permit:

Name of Organization	Address (street address, city, state, zip)	Telephone Number(s)

I, the undersigned, declare and affirm under penalties of perjury that this application for temporary permit in the state of South Dakota has been examined by me, and to the best of my knowledge and belief is in all things true and correct.

_____ _____

Applicant Signature **Date**